		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044370

Facility Name: St. Francis Nursing & Rehab Center

Address: 500 Asbury Street (Number) Evanston (City) 60202 (Zip Code)

County: Cook

Telephone Number: (847) 316-3320 **Fax #** ( )

IDPA ID Number: 237061646

Date of Initial License for Current Owners: 03/08/85

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	5013C		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Keith Winkler **Telephone Number:** (773) 594-8555

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Charles Brobst
(Title) Senior Vice President-Finance

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	78	Skilled (SNF)	78	28,548	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,384	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,298	2,593	8,706	22,597	8
9	SNF/PED					9
10	ICF	11,588	1,646	382	13,616	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,886	4,239	9,088	36,213	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/08/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/08/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 78 and days of care provided 7,476

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	297,683	27,173	8,661	333,517		333,517		333,517			1
2	Food Purchase		213,063		213,063		213,063	(3,921)	209,142			2
3	Housekeeping	157,323	17,424	15,061	189,808	(6,427)	183,381		183,381			3
4	Laundry		1,571	155,992	157,563	6,427	163,990		163,990			4
5	Heat and Other Utilities			112,769	112,769		112,769		112,769			5
6	Maintenance	2,559	13,193	35,823	51,575	49,003	100,578		100,578			6
7	Other (specify):*											7
8	**TOTAL General Services**	457,565	272,424	328,306	1,058,295	49,003	1,107,298	(3,921)	1,103,377			8
	B. Health Care and Programs											
9	Medical Director			14,028	14,028		14,028		14,028			9
10	Nursing and Medical Records	1,920,819	44,515	101,050	2,066,384	192,184	2,258,568		2,258,568			10
10a	Therapy	324,113	2,757	42,227	369,097	(81,420)	287,677		287,677			10a
11	Activities	65,182	1,901	13,393	80,476	(14,396)	66,080		66,080			11
12	Social Services	61,879	1,388	20,376	83,643		83,643		83,643			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,371,993	50,561	191,074	2,613,628	96,368	2,709,996		2,709,996			16
	C. General Administration											
17	Administrative	94,203		620,584	714,787	(145,371)	569,416		569,416			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			15,127	15,127		15,127		15,127			20
21	Clerical & General Office Expenses	199,486	7,985	37,244	244,715		244,715		244,715			21
22	Employee Benefits & Payroll Taxes			967,396	967,396		967,396		967,396			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,380	4,380	(500)	3,880		3,880			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			167,832	167,832		167,832		167,832			26
27	Other (specify):*											27
28	**TOTAL General Administration**	293,689	7,985	1,812,563	2,114,237	(145,871)	1,968,366		1,968,366			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,123,247	330,970	2,331,943	5,786,160	(500)	5,785,660	(3,921)	5,781,739			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Francis Nursing & Rehab Center #0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			376,705	376,705		376,705		376,705			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			43,789	43,789		43,789		43,789			35
36	Other (specify):*											36
37	**TOTAL Ownership**			420,494	420,494		420,494		420,494			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			15,494	15,494	500	15,994		15,994			38
39	Ancillary Service Centers		746,480	3,150	749,630	(2,209)	747,421		747,421			39
40	Barber and Beauty Shops					2,209	2,209		2,209			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,076	68,076		68,076		68,076			42
43	Other (specify):*			42,763	42,763		42,763		42,763			43
44	**TOTAL Special Cost Centers**		746,480	129,483	875,963	500	876,463		876,463			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,123,247	1,077,450	2,881,920	7,082,617		7,082,617	(3,921)	7,078,696			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,921)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,921)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,921)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St. Francis Nursing & Rehab Center

ID# 0044370

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,921)	0	0	0	0	0	0	0	0	0	0	(3,921)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,921)	0	0	0	0	0	0	0	0	0	0	(3,921)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,921)	0	0	0	0	0	0	0	0	0	0	(3,921)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St. Francis Nursing & Rehab Center** **#** **0044370** **Report Period Beginning:** **07/01/03** **Ending:** **06/30/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(3,921)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(3,921)**	**45**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care Corp.	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Managagement Fee	$ 620,584	Resurrection Health Care Corp	100.00%	$ 620,584	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 620,584			$ 620,584	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection Health Care Corp.
Street Address: 7435 W. Talcott Ave.
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Corporate Depreciation	Direct Cost	1,023,651,154	26	$ 14,462,296	$	6,462,033	$ 91,297	1
2	17	Corporate Insurance	Direct Cost	1,023,651,154	26	76,607		6,462,033	484	2
3	17	Human Resources	Direct Cost	1,023,651,154	26	6,975,948	3,513,735	6,462,033	44,037	3
4	17	Learning & Information Ctr	Direct Cost	1,023,651,154	26	1,678,058	839,171	6,462,033	10,593	4
5	17	Marketing/Public Relations	Direct Cost	1,023,651,154	26	7,272,478	120,635	6,462,033	45,909	5
6	17	RHCC Administration	Direct Cost	1,023,651,154	26	9,051,418	6,382,691	6,462,033	57,139	6
7	17	Mission Effectiveness	Direct Cost	1,023,651,154	26	1,041,597	659,763	6,462,033	6,575	7
8	17	Facilities Management	Direct Cost	1,023,651,154	26	199,030	151,426	6,462,033	1,256	8
9	17	Senior Services Admn	Direct Cost	1,023,651,154	26	506,366	374,256	6,462,033	3,197	9
10	17	Finance Admn & Accounting	Direct Cost	1,023,651,154	26	24,354,670	15,693,064	6,462,033	153,744	10
11	17	Info Svc/Data Processing	Direct Cost	1,023,651,154	26	25,745,734	11,547,402	6,462,033	162,526	11
12	17	Purchasing/Materiels Mgmt	Direct Cost	1,023,651,154	26	4,799,656	7,169,502	6,462,033	30,299	12
13	17	Risk Management	Direct Cost	1,023,651,154	26	1,130,048	1,002,795	6,462,033	7,134	13
14	17	Employee Health	Direct Cost	1,023,651,154	26	1,012,854	871,590	6,462,033	6,394	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 98,306,760	$ 48,326,030		$ 620,584	25

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Francis Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044370

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,712 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facilty		1985	$ 188,421	1
2					2
3	TOTALS			$ 188,421	3

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	124		1985	1961	$ 2,426,118	$ 80,660	30	$ 80,660	$	$ 1,579,193	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	General Construction/Renovation			1986	12,875		12			12,875	9
10	General Construction/Renovation			1986	3,543		10			3,543	10
11	General Construction/Renovation			1986	82,489		15			82,489	11
12	General Construction/Renovation			1986	44,717	2,236	20	2,236		41,220	12
13	General Construction/Renovation			1987	5,529		12			5,529	13
14	General Construction/Renovation			1987	2,560		10			2,560	14
15	Inhouse Labor			1988	7,688		5			7,688	15
16	Shower			1989	3,836	192	20	192		2,973	16
17	Lobby Refurbish/Exterior Renovation			1991	73,428		5			73,428	17
18	Dishwasher and Installation			1991	7,332		10			7,332	18
19	Sidewalk Replacement			1991	4,880		5			4,880	19
20	Remodel			1993	30,862	2,057	15	2,057		23,660	20
21	Vestibule: Wallpaper/Painting; Window Draperies			1996	4,601	307	15	307		2,454	21
22	Combustion Air Handling System			1996	24,969	2,497	10	2,497		19,975	22
23	Fire Alarm System			1996	71,668	7,167	10	7,167		57,335	23
24	Parking Lot Repaving			1997	7,162	477	15	477		3,362	24
25	Roofing: Drain flashing collar; coping replacement;										25
26	deck repair; masonry repointing; install new drains			1997	74,400	4,960	15	4,960		34,927	26
27	Admin offices: carpeting; wallpapering & painting;										27
28	electrical wiring and lighting			1997	12,270	818	15	818		5,760	28
29	Renovate 3 Nursing Floors: painting & wallpapering;										29
30	install ADA handles & mirrors; carpeting & floor										30
31	tiling; installation of glass blocks & windaow										31
32	masonry; installation & modification of light										32
33	fixtures; plumbing & H.V.A.C. sprinklers			1997	499,653	33,310	15	33,310		234,559	33
34	Security Camera System			1997	16,014	1,601	10	1,601		11,277	34
35	Parking Lot Repaving			1999	8,530	569	15	569		3,128	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Day Room Expansion & Renovation: tear down wall		$	$		$	$	$	37
38	between day room & conference room to expand day								38
39	room; install new ceiling & ceiling tiles; new florring;								39
40	wallpaper & painting; install cupboard & sink; revamp								40
41	closet; window treatment	1999	23,212	2,263	10	2,263		12,446	41
42	Remove & replace all windows on 1st, 2nd, & 3rd floors	1999	118,907	7,927	15	7,927		43,599	42
43	Aquisition and installation of sternberg lights	2000	7,400	493	15	493		2,220	43
44	Fire dampers/automatic closers	2000	21,493	1,433	15	1,433		6,448	44
45	Vonsuperior Panic Hardware for 9 doors	2000	8,058	1,151	7	1,151		5,180	45
46	Demolition of existing entrance, waiting area and								46
47	chapel entrance; install flooring, automatic door system,								47
48	anodized store front thermal glazed window system,								48
49	ceiling tile system w/ lighting, and wall covering;								49
50	relocate chapel entrance; new concrete sidewalks								50
51	and accessibilty ramp.	2000	190,424	19,042	10	19,042		85,691	51
52	Relocate portable fire extinguishers with casing &								52
53	vinyl wallcovering	2001	4,606	921	5	921		3,224	53
54	Acquisition/installation exterior concrete bench	2001	2,674	535	5	535		1,872	54
55	Acquisition/installation 54"X114" plate glass								55
56	for davroom	2001	1,350	193	7	193		675	56
57	Refinish & apply slip grips 36 bathtubs	2001	9,720	1,944	5	1,944		6,804	57
58	PT/OT renovation: demolition of 2 block walls, casework								58
59	and flooring; install new cabinets; new folding partition;								59
60	new drywall partition; new VCT flooring; paint and vinyl								60
61	wall covering; plumbing for sinks 7 sprinklers	2001	56,042	5,604	10	5,604		19,615	61
62	Parking lot expansion	2002	536,437	34,878	15	34,878		87,194	62
63	Elevator alarm system	2002	30,000	4,286	7	4,286		10,714	63
64	Building security system	2002	21,710	3,101	7	3,101		7,754	64
65	Solar shades/awning & installation	2002	5,084	708	7	708		1,771	65
66	Window air conditioners & installation	2002	10,439	1,930	5	1,930		4,825	66
67	IDPH safety code compliance- includes but not limited to:								67
68	protection of lay-in light fixtures and equipment;								68
69	automatic door closures tied into a fire alarm system which								69
70	TOTAL (lines 4 thru 69)		$ 4,472,680	$ 223,260		$ 223,260	$	$ 2,520,179	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,472,680	$ 223,260		$ 223,260	$	$ 2,520,179	1
2	is activated by smoke detectors, pull stations and sprinkler								2
3	system; installation of smoke operated fire dampers and								3
4	access panels in exhaust duct system penatrating smoke								4
5	barrier walls located on floors 1,2 and 3.	2002	481,852	46,597	10	46,597		116,492	5
6	Interior renovation-includes but not limited to:								6
7	Toli floor and ramp; carpet administration area; switch-								7
8	bank for lobby and entrance area; new light fixtures in								8
9	various area; replace piping to boilers; new condensing								9
10	unit to north window well; reheat coil in lobby; replace								10
11	bathroom fixtures; replace/upgrade ceiling in various areas;								11
12	various wall modifications; replace various bathroom								12
13	fixtures; various other electrical and plumbing								13
14	modifications.	2002	159,709	16,549	10	16,549		41,374	14
15	Exterior renovation-includes not limited to: sliding doors;								15
16	removal and replacement of concrete curbs; paving, grading								16
17	and stonework; install new fire ceiling and framing in								17
18	smoking area; new handicap signs; various electrical								18
19	work in outside waiting area (including new heaters,								19
20	intercom and doorbell).	2002	98,000	6,533	15	6,533		16,333	20
21	Lobby renovation-includes but not limited to: selective								21
22	demolition of existing lobby, toilet room, and reception								22
23	and replacement of each as well as new assisted bathing.								23
24	this includes new partions, electric plumbing, HVAC,								24
25	accoustic panel ceiling, floor finishes, doors, frames,								25
26	interior windows and casement. Floral fixtures and								26
27	artwork.	2002	166,549	11,732	14	11,732		29,331	27
28	Acquisition/installation of medical records voice and data								28
29	cables, 24-port patch panel, and fire stop & sleeves	2003	4,646	310	15	310		465	29
30	2 sewage pumps	2003	5,752	383	15	383		575	30
31	Down light style fixtures-acquisition and electrical work	2003	3,780	252	15	252		378	31
32	Elevator control valve piping	2003	10,037	1,004	10	1,004		1,506	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,403,005	$ 306,620		$ 306,620	$	$ 2,726,633	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,403,005	$ 306,620		$ 306,620	$	$ 2,726,633	1
2	Remove existing and install new nurse station (1st floor)	2004	8,300	277	15	277		277	2
3	Purchase & install quarry tile in kitchen entrance	2004	1,114	111	5	111		111	3
4	Grout kitchen floor	2004	4,740	237	10	237		237	4
5	Purchase & install raised round rubber tiles in elevator	2004	1,538	154	5	154		154	5
6	Purchase & install 2 ceiling 40-gallon ASME coded								6
7	expansion tanks	2004	3,685	369	5	369		369	7
8	Purchase & install hot water heater	2004	3,250	108	15	108		108	8
9	Purchase & install category 5E wire cable in elevator	2004	758	38	10	38		38	9
10	Replace wood floor with concrete in oxygen storage closet	2004	1,750	58	15	58		58	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,428,140	$ 307,972		$ 307,972	$	$ 2,727,985	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 671,693	$ 68,489	$ 68,489	$	10	$ 423,227	71
72	Current Year Purchases	4,889	244	244		10	244	72
73	Fully Depreciated Assets	816,547					816,547	73
74								74
75	TOTALS	$ 1,493,129	$ 68,733	$ 68,733	$		$ 1,240,018	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,109,690	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 376,705	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 376,705	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,968,003	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 43,789 Description: Copier $5,017; Kinectic beds $12,554; Infusion/IV Pumps $26,218
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, Col 1	1755 hrs	$ 52,749	146	$ 7,001	$	1,901	$ 59,750	1
2	Licensed Speech and Language Development Therapist	10a, Col 1	35 hrs	1,082	73	3,513		108	4,595	2
3	Licensed Recreational Therapist	11, Col 1	1920 hrs	29,425				1,920	29,425	3
4	Licensed Physical Therapist	10a, Col 1	1896 hrs	59,309	63	3,018		1,959	62,327	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, Col 2	# of prescrpts				667,670		667,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Chargeable Supplies	39, Col 2					78,810		78,810	13
14	TOTAL			$ 142,565	282	$ 13,532	$ 746,480	5,888	$ 902,577	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 105,871	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 517,612)	669,206		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,076		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 785,153	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,421		13
14	Buildings, at Historical Cost	5,428,140		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,493,129		16
17	Accumulated Depreciation (book methods)	(3,968,003)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,141,687	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,926,840	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,740		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	29,924		36
37	Due Affiliates	6,553,130		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,598,794	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,598,794	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,671,954)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,926,840	$	48

***(See instructions.)**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,770,014)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,770,014)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(948,757)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (948,757)	17
	B. Transfers (Itemize):		
18	**From Affiliates**	46,817	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 46,817	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,671,954)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,236,153	1
2	Discounts and Allowances for all Levels	(3,363,706)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,872,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,558,310	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,558,310	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,537	13
14	Non-Patient Meals	3,921	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	801,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	16,068	20
21	Other Medical Services	836,017	21
22	Laundry	31,537	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,692,419	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	7,356	28
28a	Misc. Other	3,328	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,684	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,133,860	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,107,298	31
32	Health Care	2,709,996	32
33	General Administration	1,968,366	33
	B. Capital Expense		
34	Ownership	420,494	34
	C. Ancillary Expense		
35	Special Cost Centers	808,387	35
36	Provider Participation Fee	68,076	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,082,617	40
41	**Income before Income Taxes (line 30 minus line 40)****	(948,757)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (948,757)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,768	2,080	$ 63,036	$ 30.31	1
2	Assistant Director of Nursing	620	698	19,112	27.38	2
3	Registered Nurses	24,221	26,932	853,409	31.69	3
4	Licensed Practical Nurses	8,475	9,423	205,401	21.80	4
5	Nurse Aides & Orderlies	62,145	68,091	829,117	12.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,686	4,198	129,002	30.73	7
8	Rehab/Therapy Aides	7,237	7,978	113,691	14.25	8
9	Activity Director	1,920	2,080	31,886	15.33	9
10	Activity Assistants	2,102	2,193	18,899	8.62	10
11	Social Service Workers	2,698	2,906	61,879	21.29	11
12	Dietician	106	106	1,699	16.03	12
13	Food Service Supervisor	4,012	4,460	77,248	17.32	13
14	Head Cook	7,235	7,599	91,341	12.02	14
15	Cook Helpers/Assistants	12,885	13,702	127,394	9.30	15
16	Dishwashers					16
17	Maintenance Workers	2,076	2,204	39,959	18.13	17
18	Housekeepers	14,639	15,967	150,897	9.45	18
19	Laundry	678	749	6,427	8.58	19
20	Administrator	1,944	2,080	94,203	45.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,660	5,333	66,236	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,887	2,164	32,813	15.16	31
32	Other Health C: Care Plan Coord	2,191	2,395	66,867	27.92	32
33	Other(specify) Chaplain	1,689	1,862	42,731	22.95	33
34	TOTAL (lines 1 - 33)	168,874	185,200	$ 3,123,247 *	$ 16.86	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,028	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,028		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	330	$ 18,766	Ln 10, Col 3	50
51	Licensed Practical Nurses	619	23,511	Ln 10, Col 3	51
52	Nurse Aides	59	1,178	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,008	$ 43,455		53

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mellman, Gary	Administrator	0	$ 94,203
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,203

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,225
Unemployment Compensation Insurance	8,075
FICA Taxes	220,620
Employee Health Insurance	529,831
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	6,743
Pension	147,314
Group Disabilty Insurance	14,854
Employee Assistance Program	2,087
Pre-Employment Medical Screen	3,561
Tuition Reimbursement	4,086
TOTAL (agree to Schedule V, line 22, col.8)	$ 967,396

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Evanston City License	8,040
Dues and subscriptions	7,087
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	502
Seminar Expense	3,378
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,880

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Francis Nursing & Rehab Center # 0044370 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network $4,615

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 45,070 Line 39

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 68,076
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Yes Indicate the amount. $ 3,921

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at time of filing

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? N/A

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.